Benefit Summary

for Dental Maximum Rollover Plan has been prepared for the employees of:

City of Brazil

Deductible- $50 individual (*Waived for Preventive Services)

	Percentage Paid
Services	
Preventive Services*	100%
Emergency Palliative Treatment	
Oral Examination - every six months	
X-Rays - four bitewings every twelve months full mouth series every five years	
Teeth Cleaning - every six months	
Fluoride Treatments - every six months (No Age Limit)	
Space Maintainers for Children - under age 16	
Topical Sealants for unrestored molar teeth -one treatment for child(ren) under 16 in a three (3) year period	
Basic Services	80%
General Anesthesia- surgical procedures only	
Laboratory Test	
Diagnostic Consultation- one per year	
Fillings: Amalgam, Silicate & Acrylic	
Injectable Antibiotics- for treatment of a dental condition only	
Major Services	50%
Crowns: Resin and Metal	
Bridges Installation-fixed and removable	
Repairs of dentures, bridgework, crowns, etc.	
Dentures- Full and Partial	
Periodontal Services/Surgery	
Oral Surgery- Uncomplicated extractions	
Endodontic Services/Root Canal Therapy	
Inlays	
Onlays	
Posts	

Benefit Summary

- There is an $1,500 annual maximum for Preventive, Basic and Major services combined, subject to Maximum Rollover.
- **Maximum Rollover:** With Maximum Rollover, we'll roll over a portion of each member's unused annual maximum, called the Maximum Rollover Amount, into his or her Maximum Rollover Account (MRA). The MRA can be used in future years, if a member reaches the plan's Annual Maximum.

  To qualify, a member must submit a claim and not exceed the paid claims Threshold during the benefit year. The employee and each insured dependent maintain separate MRAs based on their own claim activity. Each member's MRA may not exceed the MRA limit.

PLAN ANNUAL MAXIMUM	THRESHOLD	MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLLOVER ACCOUNT LIMIT
$1500	$700	$350	$1250

- *Deductible is waived for Preventive services. 3 individual deductibles per family.
- Children are covered up to age 20 or 26 if a full time student.
- Employee/Dependents enrolling outside of the plan eligibility period may be subject to Late Entrant[1] penalties.
- The following benefits are deferred for new enrollees: Major Services 12 months.
- All out of network services are based on usual, reasonable, and customary rates for given area.
- To locate a provider, please reference our On-Line Provider Directory at www.GuardianLife.com.
- Dental Claims - P. O. Box 2459, Spokane, WA 99210-2459, ph: 1-800-541-7846, fax: 509-468-4590.
- Pre-determination Review - Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over $300. Have your dentist fax your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable.
- **Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.
  R3 - DG2000

[1]A late entrant is a person who becomes insured more than 31 days after he is eligible; or becomes insured again, after his coverage lapsed because he did not make required payments. We won't cover charges incurred by a late entrant for (1) Group II (basic) services until 6 months from the date he is insured by this plan; and (2) Group III (major) services until 12 months from the date he is insured by this plan.

DentalGuard General Limitations and Exclusions: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect , or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment, The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

This handout is for illustrative purposes. You will receive benefit booklets. If there is a discrepancy between this handout and your benefit booklet, the benefit booklet prevails.

GUARDIAN®

Benefit and Cost Summary

for Vision has been prepared for the employees of:

City of Brazil

Full Feature Plan

Frequency of Service:

Exam	every 12 months
Materials:	
Lenses	every 12 months
Frames	every 24 months
Or	
Contact Lenses (in lieu of frames & lenses)	every 12 months

Note: If you chose contact lenses, you will not be eligible to receive lenses for 12 months and a frame for 24 months following the date contacts were obtained.

Copayment:

Exam	$10
Materials	$20

Benefits (after Copayment):	In-Network	Out-of-Network
Eye Exams	covered in full	up to $46.00
Single Vision Lenses	covered in full	up to $47.00
Lined Bifocal Lenses	covered in full	up to $66.00
Lined Trifocal Lenses	covered in full	up to $85.00
Lenticular Lenses	covered in full	up to $125.00
Frames	$115 Retail Allowance*	up to $47.00
Contact Lenses		
Medically Necessary	covered in full	up to $210.00
Elective	up to $105.00**	up to $120.00**

*Approximately 15,000 frames are covered in full. Frames not fully covered are offered at a discounted cost. If you select a frame that exceeds the retail allowance, the plan will cover 20% of the amount above the allowance. You must pay the rest.

** Copayment does not apply to elective contact lenses.

Note: Lens coverage includes polycarbonate lenses for children up to the plan's non-student dependent child age limits.

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary to prevent, diagnose and treat a vision condition. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-1 et al

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